		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042614

Facility Name: Golfview Developmental Center

Address: 9555 Golf Road (Number) Des Plaines (City) 60616 (Zip Code)

County: Cook

Telephone Number: (847)827-6628 **Fax #** (847) 827-0948

IDPA ID Number: 362935353001

Date of Initial License for Current Owners: 11/17/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kenneth S. Pinsky **Telephone Number:** (847) 267-9600
Warady & Davis LLP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Warady & Davis LLP, 1717 Deerfield Road, Suite 300 So., Deerfield IL 60015
(Telephone) (847) 267-9600 Fax # (847) 267-9696

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	135	Intermediate/DD	135	49,275	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	47,704			47,704	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,704			47,704	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.81%

D. How many bed-hold days during this year were paid by Public Aid?
1,036 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/17/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/17/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Golfview Developmental Center # 0042614 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	282,179	29,181	7,137	318,497		318,497		318,497			1
2	Food Purchase		189,230		189,230		189,230		189,230			2
3	Housekeeping	281,208	56,877		338,085		338,085		338,085			3
4	Laundry	62,703	8,719	25	71,447		71,447		71,447			4
5	Heat and Other Utilities			216,101	216,101		216,101		216,101			5
6	Maintenance	64,114	22,503	128,599	215,216		215,216	16,702	231,918			6
7	Other (specify):*											7
8	**TOTAL General Services**	690,204	306,510	351,862	1,348,576		1,348,576	16,702	1,365,278			8
	B. Health Care and Programs											
9	Medical Director			12,084	12,084		12,084		12,084			9
10	Nursing and Medical Records	2,427,792	50,188	123,458	2,601,438		2,601,438		2,601,438			10
10a	Therapy			15,503	15,503		15,503		15,503			10a
11	Activities	88,377	4,607	95,571	188,555		188,555		188,555			11
12	Social Services	38,231		6,050	44,281		44,281		44,281			12
13	Nurse Aide Training	83,440			83,440		83,440		83,440			13
14	Program Transportation					18,730	18,730		18,730			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,637,840	54,795	252,666	2,945,301	18,730	2,964,031		2,964,031			16
	C. General Administration											
17	Administrative	179,165		459,486	638,651		638,651	(459,486)	179,165			17
18	Directors Fees											18
19	Professional Services			153,058	153,058		153,058		153,058			19
20	Dues, Fees, Subscriptions & Promotions			47,418	47,418		47,418	(963)	46,455			20
21	Clerical & General Office Expenses	129,173	39,945	70,109	239,227		239,227	(691)	238,536			21
22	Employee Benefits & Payroll Taxes			740,972	740,972		740,972	(624)	740,348			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,351	4,351		4,351		4,351			24
25	Other Admin. Staff Transportation			24,973	24,973	(18,730)	6,243		6,243			25
26	Insurance-Prop.Liab.Malpractice			98,934	98,934		98,934	45,851	144,785			26
27	Other (specify):*											27
28	**TOTAL General Administration**	308,338	39,945	1,599,301	1,947,584	(18,730)	1,928,854	(415,913)	1,512,941			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,636,382	401,250	2,203,829	6,241,461		6,241,461	(399,211)	5,842,250			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Golfview Developmental Center #0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			17,603	17,603		17,603	342,647	360,250			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,531	4,531		4,531	510,793	515,324			32
33	Real Estate Taxes							237,788	237,788			33
34	Rent-Facility & Grounds			1,085,845	1,085,845		1,085,845	(1,085,845)				34
35	Rent-Equipment & Vehicles			50,120	50,120		50,120		50,120			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,158,099	1,158,099		1,158,099	5,383	1,163,482			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		753		753		753		753			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			411,602	411,602		411,602		411,602			42
43	Other (specify):*			15,157	15,157		15,157	(15,157)				43
44	**TOTAL Special Cost Centers**		753	426,759	427,512		427,512	(15,157)	412,355			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,636,382	402,003	3,788,687	7,827,072		7,827,072	(408,985)	7,418,087			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	881	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(3,692)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(13,077)	43		19
20	Contributions	(1,945)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(100)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(461,799)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (479,732)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	54,045		34
35	Other- Attach Schedule	16,702	6	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 70,747		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (408,985)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2004

Schedule 5a

Page 5 - Other Expense Adjustments

Description	Amount
Amortization of prior year deferred maintenance	16,702
	16,702

See Accountants' Compilation Report

STATE OF ILLINOIS

Golfview Developmental Center

ID# 0042614

Report Period Beginning: 1/1/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Management Fees	$ (459,486)	17	1
2	Dues and Subscriptions	(963)	20	2
3	Finance Charges	(35)	43	3
4	Gifts	(624)	22	4
5	Bank Charges	(691)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(461,799)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	16,702	0	0	0	0	0	0	0	0	0	0	16,702	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	16,702	0	0	0	0	0	0	0	0	0	0	16,702	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(459,486)	0	0	0	0	0	0	0	0	0	0	(459,486)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(963)	0	0	0	0	0	0	0	0	0	0	(963)	20
21	Clerical & General Office Expenses	(691)	0	0	0	0	0	0	0	0	0	0	(691)	21
22	Employee Benefits & Payroll Taxes	(624)	0	0	0	0	0	0	0	0	0	0	(624)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	45,851	0	0	0	0	0	0	0	0	0	45,851	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(461,764)	45,851	0	0	0	0	0	0	0	0	0	(415,913)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(445,062)	45,851	0	0	0	0	0	0	0	0	0	(399,211)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	881	341,766	0	0	0	0	0	0	0	0	0	342,647	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,692)	514,485	0	0	0	0	0	0	0	0	0	510,793	32
33	Real Estate Taxes	0	237,788	0	0	0	0	0	0	0	0	0	237,788	33
34	Rent-Facility & Grounds	0	(1,085,845)	0	0	0	0	0	0	0	0	0	(1,085,845)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,811)	8,194	0	0	0	0	0	0	0	0	0	5,383	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(15,157)	0	0	0	0	0	0	0	0	0	0	(15,157)	43
44	**TOTAL Special Cost Centers**	(15,157)	0	0	0	0	0	0	0	0	0	0	(15,157)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(463,030)	54,045	0	0	0	0	0	0	0	0	0	(408,985)	45

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bertram Miner	100			Golfview Realty Partnership d/b/a Golfview Partnership Venture	Chicago	Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	26	Insurance	$	Golfview Realty Partnership	100.00%	$ 45,851	$ 45,851	1
2	V	30	Depreciation		Golfview Realty Partnership	100.00%	341,766	341,766	2
3	V	32	Interest Expense		Golfview Realty Partnership	100.00%	515,955	515,955	3
4	V	33	Real Estate Taxes		Golfview Realty Partnership	100.00%	237,788	237,788	4
5	V	32	Interest Income	1,470	Golfview Realty Partnership	100.00%		(1,470)	5
6	V	34	Rent Expense	1,085,845	Golfview Realty Partnership	100.00%		(1,085,845)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,087,315			$ 1,141,360	$ * 54,045	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Anthony Miner*	President	Administrator	None	None	70-80	100.00	Salary	$ 116,896		1
2											2
3	* Son of Bertram Miner										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 116,896		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Capstone Realty Advisors		X	Mortgage	$48,209.00	4/17/03	$ 9,225,000	$ 9,119,370	5/31/2043	5.6000	$ 512,575	1
2	Capstone Realty Advisors		X	Mortgage Costs							3,380	2
3	First Insurance Funding Corp		X	Insurance Financing							432	3
4	Interest Income Offset		X								(5,308)	4
5	Shareholder Loan	X		Working Capital	Interest Only	Various	786,009	646,009	Demand	7.0000	7,937	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$48,209.00		$ 10,011,009	$ 9,765,379			$ 519,016	9
	B. Non-Facility Related*											
10	Shareholder Loan	X		Working Capital - Excess interest over prime paid to related party							(3,692)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,692)	14
15	TOTALS (line 9+line14)						$ 10,011,009	$ 9,765,379			$ 515,324	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 45,851** **Line # 26**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	122,943	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	233,966	2
3. Under or (over) accrual (line 2 minus line 1).	$	111,023	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	126,765	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	237,788	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	266,574	8
	2000	271,018	9
	2001	224,336	10
	2002	223,514	11
	2003	230,482	12

2003 Tax Assessment	230,482
5% Increase	x 1.05
2004 Estimated Taxes	242,006
Use	126,765 ($242,006 less $115,241 paid on 12/20/04)

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golfview Developmental Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042614

CONTACT PERSON REGARDING THIS REPORT Anthony Miner

TELEPHONE (847) 827-6628 FAX #: (847) 827-0948

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-100-013-0000	9555 Golf Road, Des Plaines, IL	$ 213,640.00	$ 213,640.00
2.	09-15-100-012-0000	9555 Golf Road, Des Plaines, IL	$ 16,842.00	$ 16,842.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 230,482.00	$ 230,482.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,011 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Residential Care	117,000	1977	$ 234,000	1
2					2
3	TOTALS	117,000		$ 234,000	3

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		1997	1997	$ 8,641,370	$	40	$ 216,034	$ 216,034	$ 1,530,294	4
5			1997		(580,616)		39	(14,888)	(14,888)	(97,539)	5
6			1998		40,292		40	1,007	1,007	6,547	6
7	7		1999	1999	52,495		40	1,312	1,312	7,217	7
8											8
	Improvement Type**										
9	Fencing			1997	1,200	120	10	120		900	9
10	Lobby notice board			1998	3,380	338	10	338		2,197	10
11	Parking Lot			1998	139,900		15	9,327	9,327	60,624	11
12	Exhaust system			1999	2,801		10	280	280	1,540	12
13	Compressor			1999	11,972		10	1,197	1,197	6,585	13
14	Fencing			1999	1,800		10	180	180	990	14
15	Fire Vents			1999	1,806		10	181	181	994	15
16	Elevator			1999	932		10	93	93	513	16
17	Security system			1999	970		10	97	97	534	17
18	Heating Unit			2000	715		10	72	72	322	18
19	Security system			2000	2,017		10	202	202	908	19
20	Telephone line			2000	7,234		10	723	723	3,255	20
21	Security system			2000	2,087	208	10	208		938	21
22	Specialty wiring & Oxygen lines			2001	567,060		10	56,706	56,706	226,824	22
23	Security system			2001	4,803	480	10	480		1,681	23
24	Security system			2001	17,731	1,773	10	1,773		6,206	24
25	Fire alarm system			2001	7,583	758	10	758		2,654	25
26	Security system			2002	4,402	440	10	440		1,100	26
27	Hot water tanks			2002	3,142	314	10	314		785	27
28	Hot water pipes			2003	9,150	915	10	915		1,525	28
29	Title and wall coverings			2003	4,190	419	10	419		559	29
30	Door			2003	3,624	362	10	362		482	30
31	Resident room repair			2003	5,314	531	10	531		531	31
32	2 new faucets			2003	2,308	231	10	231		231	32
33	Floor repair			2004	5,966	497	10	497		497	33
34	Drywall			2004	6,749	562	10	562		562	34
35	Repair walls			2004	15,133	507	10	507		507	35
36	Dishwasher			2004	2,850	119	10	119		119	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Hot water piping	2004	$ 3,458	$ 58	10	$ 58	$	$ 58	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,993,818	$ 8,632		$ 281,155	$ 272,523	$ 1,771,140	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 884,334	$ 6,965	$ 77,214	$ 70,249	5-10 years	$ 679,141	71
72	Current Year Purchases	37,847	1,881	1,881		5-10 years	1,881	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 922,181	$ 8,846	$ 79,095	$ 70,249		$ 681,022	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,149,999	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,478	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 360,250	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 342,772	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,452,162	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 10,695 Description: Ice Machine $3,720; Copier $4,781; Postage $388; Rental car $1,661; Miscellaneous $145
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Transport	2003 Ford Econo Wagon	$ 550.00	$ 6,598	17
18	Resident Transport	2003 Ford Econo Wagon	634.00	7,605	18
19	Resident Transport	2001 Cherolet Van	589.00	4,710	19
20	See attached schedule 14a			20,512	20
21	TOTAL		$ 1,773.00	$ 39,425	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2004

Schedule 14a

Page 14 - Vehicle Rental

Use	Model Year & Make	Monthly Lease Payment	Rental Expense for this period
Resident Transportation	2001 Chevrolet Van	715.00	5,002
Resident Transportation	2004 Ford Econoline Van	604.00	4,889
Resident Transportation	2004 Ford Econoline Van	651.00	5,161
Administrative	2003 Acura	455.00	5,460
			20,512

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 90

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	5,927	13,829		19,756
4	Clinical Wages	(b)	7,409	17,286		24,695
5	In-House Trainer Wages	(c)	11,696	27,293		38,989
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 25,032	$ 58,408	$	$ 83,440
10	SUM OF line 9, col. 1 and 2	(e)	$ 83,440			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	35
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	15
2. From other facilities (f)	
TOTAL TRAINED	50

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	L39,C2	visits				46		46	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Optical	L39,C2					707		707	13
14	TOTAL			$		$	$ 753		$ 753	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,962	$ 111,745	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,159,167	2,159,167	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,720	28,743	6
7	Other Prepaid Expenses	9,297	9,297	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17a		302	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,188,146	$ 2,309,254	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		234,000	13
14	Buildings, at Historical Cost		8,710,554	14
15	Leasehold Improvements, at Historical Cost	104,331	244,232	15
16	Equipment, at Historical Cost	131,812	922,181	16
17	Accumulated Depreciation (book methods)	(92,635)	(2,446,314)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17a	1,675	434,248	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 145,183	$ 8,098,901	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,333,329	$ 10,408,155	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 336,296	$ 336,296	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	272,620	272,620	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,765	32
33	Accrued Interest Payable	6,001	6,001	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17a	2,786,279	2,505,735	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,401,196	$ 3,247,417	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,119,370	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,119,370	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,401,196	$ 12,366,787	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,067,867)	$ (1,958,632)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,333,329	$ 10,408,155	48

***(See instructions.)**

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2004

Schedule 17a

Page 17 - Balance Sheet	**Operating**	**After Consolidation**
Line 9 - Other Current Assets		
Assets Limited as to Use, Required for Real Estate Taxes & Insurance	-	302
Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required for Replacement Reserves	-	308,896
Deposits	1,675	1,675
Mortgage Costs	-	129,195
Accumulated Amortization - Mortgage Costs	-	(5,518)
	1,675	434,248
Line 36 - Other Current Liabilities		
Due to Shareholders	646,009	646,009
Provider Participation Fees Payable	256,507	256,507
Due to 3rd-Party Payor	303,888	303,888
Accrued Management Fees	1,299,331	1,299,331
Due to Affiliates	280,544	-
	2,786,279	2,505,735

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,053,493)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,053,493)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(14,374)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (14,374)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,067,867)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,614,868	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,614,868	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	58,004	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 58,004	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bedhold Early Discharge	136,033	28
28a	Cancellation of Indebtedness - Bankruptcy	3,793	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 139,826	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,812,698	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,348,576	31
32	Health Care	2,945,301	32
33	General Administration	1,947,584	33
	B. Capital Expense		
34	Ownership	1,158,099	34
	C. Ancillary Expense		
35	Special Cost Centers	15,910	35
36	Provider Participation Fee	411,602	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,827,072	40
41	**Income before Income Taxes (line 30 minus line 40)****	(14,374)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (14,374)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2004

Schedule 19a

Net loss for the year per page 19 does not agree to taxable loss on the Federal Income Tax Return because this entity is a cash basis taxpayer.

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,670	1,722	$ 54,644	$ 31.73	1
2	Assistant Director of Nursing	340	348	8,716	25.05	2
3	Registered Nurses	2,622	2,769	60,976	22.02	3
4	Licensed Practical Nurses	9,821	10,416	234,997	22.56	4
5	Nurse Aides & Orderlies	2,490	2,547	30,979	12.16	5
6	Nurse Aide Trainees	5,417	5,417	44,451	8.21	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,953	2,106	31,733	15.07	9
10	Activity Assistants	5,085	5,591	56,645	10.13	10
11	Social Service Workers	1,812	2,091	38,231	18.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,933	2,091	43,620	20.86	14
15	Cook Helpers/Assistants	20,735	22,274	238,559	10.71	15
16	Dishwashers					16
17	Maintenance Workers	3,436	4,203	64,114	15.25	17
18	Housekeepers	23,172	25,655	281,208	10.96	18
19	Laundry	5,763	6,073	62,703	10.32	19
20	Administrator	1,811	2,091	116,896	55.90	20
21	Assistant Administrator	1,802	2,126	62,269	29.29	21
22	Other Administrative	1,798	2,091	36,179	17.30	22
23	Office Manager	1,852	2,091	49,045	23.46	23
24	Clerical	4,447	4,704	43,949	9.34	24
25	Vocational Instruction					25
26	Academic Instruction	1,821	2,091	38,988	18.65	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	12,336	13,594	213,529	15.71	28
29	Resident Services Coordinator	1,854	2,091	37,476	17.92	29
30	Habilitation Aides (DD Homes)	145,740	159,126	1,786,475	11.23	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	259,710	283,308	$ 3,636,382 *	$ 12.84	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	149	$ 7,137	L1,C3	35
36	Medical Director	98	12,000	L9,C3	36
37	Medical Records Consultant	2	585	L10,C3	37
38	Nurse Consultant	490	31,266	L10,C3	38
39	Pharmacist Consultant	96	3,240	L10,C3	39
40	Physical Therapy Consultant	68	3,038	L10A,C3	40
41	Occupational Therapy Consultant	96	4,298	L10A,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	182	8,168	L10A,C3	43
44	Activity Consultant	1,299	111,821	L11,C3	44
45	Social Service Consultant	121	6,050	L12,C3	45
46	Other(specify)				46
47	Psychologist	40	2,706	L10,C3	47
48	Psychiatrist	12	1,800	L10,C3	48
49	TOTAL (lines 35 - 48)	2,653	$ 192,109		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	693	$ 32,272	L10,C3	50
51	Licensed Practical Nurses	844	39,993	L10,C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,537	$ 72,265		53

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Miner	Administrator	0.00	$ 116,896
Daniel Knefley	Asst. Administator	0.00	24,140
Barbara Waters	Asst. Administator	0.00	38,129
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 179,165

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KMZ Roseman	Legal	$ 82
Personnel Planner, Inc	U/C Consultants	1,440
Shaw, Gussis, Fishman, Glantz	Legal	3,553
Shayman, Salk, Aren, Suss & Co	Legal	85
Shefsky & Froelich Ltd	Legal	22,032
Warady & Davis LLP	Accounting	12,900
Wildman, Harrold, Allen & Dixon	Legal	30,508
Winston & Strawn	Legal	70,920
Wiss, Janney, Elstner Assoc	Legal	11,538
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 153,058

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 115,339
Unemployment Compensation Insurance	34,277
FICA Taxes	281,562
Employee Health Insurance	123,119
Employee Meals	41,391
Illinois Municipal Retirement Fund (IMRF)*	
Union Health & Welfare	91,080
Other Employee Benefits	53,580
TOTAL (agree to Schedule V, line 22, col.8)	$ 740,348

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,700
Advertising: Employee Recruitment	28,638
Health Care Worker Background Check	
(Indicate # of checks performed 98)	1,583
Illinois Health Care Association	7,938
Secretary of State	403
Cook County Departments	660
Miscellaneous Licenses and Fees	2,533
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,455

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,351
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,351

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Painting & Decorating	8/2001	$ 100,212	3 yrs	$ 16,702	$ 33,404	$ 33,404	$ 16,702	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 100,212		$ 16,702	$ 33,404	$ 33,404	$ 16,702	$	$	$	$	$

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc ($7,938)**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,067** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **411,602**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **41,391** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **75%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.